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No. 00-690

Supreme Court, U.S.
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IN THE
SUPREME COURT OF THE UNITED STATES

DENNIS L. MCCLATCHEY

Petitioner,

v.

UNITED STATES OF AMERICA,

Respondent.

On Petition for A Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit

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BRIEF OF FLORIDA ACADEMY OF HEALTH CARE ATTORNEYS, GREATER KANSAS CITY SOCIETY OF HEALTH CARE ATTORNEYS, HEALTH CARE LAW SECTION OF THE STATE BAR OF MICHIGAN, KANSAS ASSOCIATION OF HOSPITAL ATTORNEYS AND OKLAHOMA HEALTH LAWYERS ASSOCIATION AS AMICI CURIAE IN SUPPORT OF PETITIONER

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QUESTION PRESENTED

Whether the court of appeals erred in adopting the "one purpose" test under the Medicare Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b), by which a jury may convict a health care provider of a federal felony if any part of a health care business relationship contemplates possible patient referrals.

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This *amicus curiae* brief is submitted in support of Petitioner, Dennis McClatchey. By letters filed with the Clerk of the Court, Petitioner and Respondent have consented to the filing of this brief.[1]

INTEREST OF AMICI CURIAE

The Florida Academy of Health Care Attorneys ("FAHA") consists of 150-plus members who are attorneys practicing in the health care field. Individual members represent hospitals and healthcare systems in Florida, as well as physicians' practices, nursing homes, managed care companies and other healthcare related businesses throughout the state. FAHA is a membership group of the Florida Hospital Association, a non-profit organization formed to further and improve hospitals and healthcare in the state. FAHA provides its members with opportunities for education, discussion, professional interaction and consultation. It also advocates for the interests of its members when practice issues affecting the healthcare industry are at stake.

The Greater Kansas City Society of Healthcare Attorneys ("GKCSHA") consists of 96 members – all healthcare attorneys. Collectively, the membership represents at least 200 hospitals, as well as physicians' practices, nursing homes, managed care companies and other healthcare related businesses throughout Missouri and Kansas. The GKCSHA was organized in 1989 as a non-profit organization to "further and improve the practice of law with special emphasis upon hospital and healthcare law and regulation" and to contribute to continuing legal education in accordance with the pertinent statutes of both Missouri and Kansas. Like FAHA,

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[1] As required by Rule 37.6 of this Court, the *amici curiae* submit the following: no party or party's counsel authored this brief in whole or in part; no person or entity other than *amici curiae*, their members, or their counsel, have made a monetary contribution to the preparation or submission of this brief.

GKCSHA provides its members with opportunities for education, discussion, professional interaction and consultation and advocates for the interests of its members when global practice issues are at stake.

The Health Care Law Section of the State Bar of Michigan has over 800 members.[2] Membership in the Section is open to all members of the State Bar of Michigan. The Section provides education, information and analysis about issues of concern in the health care industry through meetings, seminars, a web site, public service programs, and various publications.

The Kansas Association of Hospital - Attorneys ("KAHA") consists of 72 members who practice healthcare law, representing hospitals, physician practices, nursing homes, and other healthcare related businesses. Its members come from all across the State of Kansas. KAHA provides its members with opportunities for continuing legal education, professional interaction and consultation in the healthcare field.

The Oklahoma Health Lawyers Association ("OHLA") was formed in 1987 as an affiliated organization of the Oklahoma Hospital Association for attorneys whose practices consist largely of health law matters. It presently boasts 80 members, each of whom devotes a substantial portion of his or her practice to the representation of health care providers and is committed to improving the quality of the practice of law in Oklahoma through continuing education and similar activities. The Bylaws of the OHLA describe the purposes of the organization as follows: (i) to provide an opportunity for lawyers to exchange information and ideas; (ii) to sponsor seminars of interest to lawyers; (iii)

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[2] It is only the Section that has agreed to support this brief. Statements made on behalf of the Section do not necessarily reflect the views of the State Bar of Michigan.

to encourage the exchange of information relating to health law; (iv) to establish a network of health lawyers to assist other lawyers who may have an interest or who may represent clients in the health care field; (v) to publish newsletters and other publications of interest in the area of health law; (vi) to conduct legal and other research and to publish or offer for publication the results of such research; (vii) to study and evaluate legislative proposals; and (viii) to engage in other activities which further these purposes.

The foregoing organizations all have a palpable interest in having this Court resolve the uncertainty surrounding the interpretation of the Medicare Anti-Kickback Statute by the federal courts, specifically as it relates to the various standards used to determine whether a defendant's conduct exhibits the intent to induce referrals. Each of the foregoing organizations agrees that the "one purpose" test adopted by the Tenth Circuit below is contrary to the intent of Congress and enforcement agencies, as reflected by statutory amendments, regulations and advisory opinions.

Legal representation of the health care industry may be compromised by the Tenth Circuit's interpretation, because it places health care attorneys in an impossible position to reconcile a myriad of conflicting statements and interpretations in advising their clients. Moreover, conscientious, law-abiding attorney-members of these organizations may themselves be at risk of criminal indictment under this overly-restrictive standard. Aggressive prosecutors may target these attorneys if circumstantial evidence suggests that a client engaged in one of many beneficial transactions that are common in the health care field, that the client was motivated "at least in part" by the expectation and desire to obtain patient referrals from the transaction, and that the lawyer prepared the legal documentation of that transaction.

These organizations are also concerned that the continuation and spread of the "one purpose" test for determining violations of the Anti-Kickback Statute will adversely affect the practice of law and the ability of health care attorneys to represent their clients effectively. This interpretation of the Statute hinders the full and frank disclosure and atmosphere of trust that is a central part of the attorney-client relationship. Moreover, the risks posed to attorneys practicing in this uncertain field will result in a dramatic and unnecessary increase in legal costs to an industry for which cost-containment is an ever-present concern.

INTRODUCTION

Attorneys practicing in the health care field took special notice when Petitioner, along with two lawyers who had advised the hospital for which Petitioner served as an executive officer, was indicted for violations of the Medicare Anti-Kickback Statute. 42 U.S.C. § 1320a-7b. The immediate and close scrutiny of the case surfaced due to the unique nature of the prosecution, fairly characterized as unprecedented in multiple respects. *First*, the allegations in the indictment focused upon the implementation of contracts for administrative services, which are commonly entered into in the ordinary course of business between hospitals and physicians and which the government conceded were lawful on their face. *Second*, the government advanced the theory that the Statute would be violated even if the payment to the doctors under the contracts had a legitimate purpose and even if the hospital did not require referrals in exchange for the payments, so long as the hospital entered the relationship in part out of a desire for patient referrals. *Third*, the government contended that such an arrangement was unlawful, even if the program developed in the contract was beneficial to patient care, did not result in any unnecessary treatment, and provided efficiencies that saved the Medicare program money. *Fourth*, the indictment was the first to

name lawyers, based on the lawyers' conduct in providing legal advice and drafting assistance in the preparation of these routine contracts. *Fifth*, the indictment (issued in 1998) alleged conduct spanning a ten-year period (from 1984 to 1995), during which time the facially vague Anti-Kickback Statute was interpreted in shifting and inconsistent ways by courts, the enforcement agency, the Congress and industry commentators.

Health care attorneys, who are regularly called upon to review the past practices of their clients and to provide advice regarding the legality of proposed future transactions, hoped that resolution of this case would clarify some of the ambiguity arising out of previous applications of the Anti-Kickback Statute. Unfortunately, the Tenth Circuit's decision instead produced tension with the case law of other courts and the administrative guidance of enforcement agencies, and thereby generated even more uncertainty for health care providers and their counsel. This confusion, arising in the context of an important federal statute that impacts every consumer of health care services, raises questions of substantial importance that should be resolved definitively by this Court now.

SUMMARY OF ARGUMENT

The Tenth Circuit approved a jury instruction that permits juries in that jurisdiction to convict defendants under the Anti-Kickback Statute if the defendants had, as "one purpose" of the transaction at issue in the indictment, the purpose "to induce" patient referrals for services payable by Medicare. Courts in other circuits, including the First, Eighth, Ninth and Eleventh, have adopted different formulations of the Statute's "inducement" requirement. Those interpretations permit conviction only if the defendant acted with a "primary purpose" or a "material purpose" to induce referrals. These semantic differences have real world consequences for defendants and the attorneys who give

legal advice. The "one purpose" test broadly criminalizes an array of normal business relationships that are historically recognized as legitimate and that in no way harm the Medicare program. Both the "material purpose" test and "primary purpose" test hew closer to congressional intent in confining the reach of the Statute to schemes designed to "pay for patients."

Health care lawyers face particular difficulties in advising clients concerning the legality of proposed transactions and practices their clients would like to adopt. Not only does the law differ in different jurisdictions, but the impossibility of administering a "one purpose test" makes legal advice so equivocal as to be useless to a client who is, in good faith, attempting to abide by the law. This uncertainty on the part of the advice-givers leads to client frustration and a break-down in the normal communicative channels that are essential to a well-functioning attorney-client relationship. Because the Anti-Kickback statute is an important federal initiative, the enforcement of which will have effects on all who consume health care services, it is important for this Court to grant certiorari now to clear the interpretive confusion among the courts and in the industry.

ARGUMENT

Health care lawyers have struggled to provide clear guidance to clients concerning the application of the Anti-Kickback Statute, 42 U.S.C. § 1320a-7b, since the original enactment of the Statute in 1972. Part of the difficulty lies in the breadth of the statutory language, which by its terms appears to prohibit a host of beneficial transactions, historically recognized as legitimate business practices that are inherently necessary to the delivery of quality medical care in an economically efficient manner. Definitive answers to questions about the application of the Statute to everyday health care transactions are further obscured by the unclear relationship among various undefined elements in

the Statute, such as the intent requirement (to act "knowingly and willfully") and the purpose requirement embedded within the *actus reus* (offer "to induce" or solicit "in return for").

The direction that has come from courts and agency pronouncements has only exacerbated the difficulties arising from the interpretation of the Statute on a blank slate. Various courts have approved jury instructions that differ materially from each other, causing certain behaviors to be arguably acceptable within one jurisdiction and not others. The different approaches in different jurisdictions leaves health care attorneys without means to advise clients with any clarity or certainty how to behave in a manner that complies with the law. This inability leads to a less communicative and productive attorney-client relationship, and will likely exacerbate, rather than mitigate, core instances of health care fraud.

I. The Tenth Circuit's Approval of a Jury Instruction Permitting Conviction If a Desire For Referrals Was One Purpose of the Transaction Collides With The Interpretation of the Statute Espoused In Other Circuits

The Anti-Kickback Statute imposes felony sanctions on any person who

> [K]nowingly and willfully offers or pays any remuneration (including any kickback, bribe or rebate) . . . to any person to induce such person . . . to refer an individual to a person for the furnishing . . . of any item or service for which payment may be made in whole or part under a State health care program.

42 U.S.C § 1320a-7b(b)(2)(A). The Tenth Circuit approved a jury instruction explaining the meaning of the requirement

that the offer of remuneration be "to induce" referrals as follows:

> To offer or pay remuneration to induce referrals means to offer or pay remuneration with the intent to gain influence over the reason or judgment of a person making referral decisions. The intent to gain such influence must, *at least in part*, have been the reason the remuneration was offered or paid.

Pet. App. 20a (emphasis in original). The District Court stressed in its instruction that the defendants could not be convicted if the remuneration "was designed wholly for other purposes." *Id.* Accordingly, the Tenth Circuit reinstated Petitioner's conviction based on a 1993 contract that "appears to encompass a legal arrangement," simply because "the evidence supports a reasonable inference that McClatchey never would have supported negotiating and entering into that contract absent his intent to induce the LaHues to continue referring their patients to Baptist." *Id.* at 10a.

The Tenth Circuit's conclusion flowed from *United States v. Greber*, 760 F.2d 68, 69 (3d Cir. 1985), which held, in the context of a classic kickback arrangement, that "if one purpose of the payment was to induce future referrals, the medicare statute has been violated." *Greber* was one of the first cases to be decided under the amended Anti-Kickback Statute, and occurred at a time before the need for cost-containment and managed care became pervasive in the health care industry. *Greber* quickly became viewed as outdated given the realities of the health care industry and subsequent changes in the Statute, and was rejected or largely ignored by subsequent courts interpreting the Statute.

In *United States v. Bay State Ambulance and Hospital Rental Service*, 874 F.2d 20, 29 (1st Cir. 1989), the district court gave the following instruction:

> [T]he Government has to prove that the payments were made with a corrupt intent, that they were made for an improper purpose. If you find that payments were made for two or more purposes, then the Government has to prove that the improper purpose is the *primary purpose* or was the *primary purpose* in making and receiving the payments. It need not be the only purpose, but it must be the primary purpose for making the payments and for receiving them. You cannot convict if you find that the improper purpose was an incidental or minor one in making the payments. (Emphasis added.)

On appeal by the convicted defendant, the Court held this instruction was consistent with the congressional intent. *Id.* at 30. It commented that the verdict indicated the jury had correctly applied the instruction, because the jurors acquitted the defendant on some counts for which they may have believed that the "payments were compensation for work done with only an incidental improper purpose." *Id.*

Courts in the Eighth Circuit have followed *Bay State* in instructing the jury. In *United States v. Jain*, 93 F.3d 436 (8th Cir. 1996), the Court stated that the Anti-Kickback Statute prohibits "willful conduct—receiving remuneration *for referring patients*," *id.* at 440, and thereby requires an instruction that the defendant knew he was acting wrongfully. The jury in *Jain* was told it must acquit if the defendant "believed he was being paid for promoting North Hills, not for referring patients." *Id.* This intent instruction comported with the "inducement" definition given to the jury in that case, permitting conviction only if "the remuneration was . . . paid *primarily* in order to induce" referrals. *United States v. Jain*, Nos. 94-00087-01, 94-00087-02-CR-W-6 (W.D. Mo. 1995), *aff'd in part and rev'd in part on other grounds*, 93 F.3d 436 (8th Cir. 1996) (Instruction N).

Courts in the Ninth and Eleventh Circuits have taken yet a different approach in reconciling the Statute's "knowing and willful" requirement with the "inducement" element. In *Hanlester v. Shalala*, 51 F.3d 1390, 1399 (9th Cir. 1995), the Ninth Circuit considered the application of the Anti-Kickback Statute to joint venture agreements with laboratories that "were fairly common" in the industry. Despite "ample evidence that appellants intended to encourage limited partners to refer business to the joint venture laboratories," the Court held that "[t]he fact that a large number of referrals resulted in the potential for a high return on investment . . .[was] insufficient to prove that appellants offered or paid remuneration to induce referrals." *Id.* Accordingly, the Court held the evidence insufficient to prove "knowing and willful" violations by those who did not condition the amount of participation in the venture according to the amount of business referred. *Id.* at 1400. Consistent with this guidance, courts in the Ninth and Eleventh Circuits direct that defendants may only be convicted if their desire to induce referrals is a "material purpose[]" of the transaction. *United States v. Kats*, 871 F.2d 105, 108 n. 1 (9th Cir. 1989); *United States v. Siegel*, 94-156-CR-T-23C (M.D. Fla. 1996), *aff'd in part and rev'd in part on other grounds United States v. Starks*, 157 F.3d 833 (11th Cir. 1998) (instructions required that "one *material* purpose, that is an *important* purpose, of the payment is to induce referrals") (emphasis added).

II. The Various Approaches to the Statute Leave Health Care Lawyers Unable To Assist Clients In Structuring Normal Business Relationships Legally

The confusion exhibited in these varying descriptions of the intent and inducement requirements of the Statute arises from the perception of some courts and advocates that the "one purpose" standard, if taken seriously, would prohibit any economic incentives paid to establish a delivery system

for efficient medical care – a result that is absurd in the context of industry realities. The transition toward managed care from a fee-for-service model makes the absurdity abundantly clear. Physician providers offer services to a managed care plan at a discounted rate (PPOs and some HMOs) or fixed fee (HMOs), in order to assure a steady stream of patient referrals from the plan. By its nature, the decision of both parties to these transactions is influenced by the desire to obtain or provide referrals, and the payment structure thereby influences the doctors' decisions about the patients' medical care. *See Pegram v. Herdrich*, 120 S. Ct. 2143, 2149 (2000). Even in a fee-for-service regime, providers constantly make economic decisions that will optimize both the quality and quantity of care.

Health care attorneys are met with a deluge of requests for advice concerning the legality of an array of ordinary business practices under the Anti-Kickback Statute. For instance, these attorneys evaluate programs conferring hospital staff privileges. By their nature, staff privileges involve the conferring of a benefit on a physician – the right to use hospital facilities (*i.e.* a remuneration) – and the expectation that the physician will use the hospital to treat his or her own patients (*i.e.* a referral). Often, hospitals consider the number of treatments performed by the applying physician at that hospital to ensure the hospital has sufficient experience with the physician's abilities to admit him or her. May a jury infer that the hospital or its executives have violated the Statute by considering the number of patients the doctor has brought to the hospital in order to assure itself that the doctor is qualified? A health care attorney's conclusion in this regard cannot, in any case, give a clear answer. But counsel's assessment of risk will differ in a jurisdiction that has approved an instruction that the offer to induce must be one purpose, rather than a material purpose or a primary purpose, of the transaction. And how should an attorney advise clients that operate in two different jurisdictions (such

as those based in Kansas City, which often have facilities both in Kansas – under the province of the Tenth Circuit, and Missouri – under the province of the Eighth)? The growth of multistate health care systems in the 1990s only exacerbates the quandary. For example, Ascension Health spans eight federal judicial circuits (http://www.ascensionhealth.com) and Tenet spans nine (http://www.tenethealth.com).

Similar problems arise when health care providers seek advice regarding physician recruitment standards. Hospitals wishing to recruit physicians to locate to a hospital's service area following completion of residency historically have paid moving allowances and income guarantees. In making the decision whom to recruit, a hospital necessarily evaluates its needs for various types of specialists, which evaluation includes an assessment of the community's demographics and possibly anticipated referral rates. As with staff privileges, a health care attorney's assessment of the risks associated with these practices will vary depending on the jurisdiction in which the hospital acts.

A third example may be seen in the context of offering payment to provide services as medical directors of programs and clinics run by a hospital for a fee. A hospital may have a choice between two candidates, both qualified, but one who has a nationally renowned reputation and a large patient following. If the hospital selects the well-known practitioner and pays a fee commensurate with that practitioner's level of experience, not only because the hospital believes his or her reputation will increase hospital business generally but also because it hopes that the more renowned medical director will treat his or her large number of patients at the hospital, is the hospital at risk of a felony conviction because "one purpose" of the decision was to maximize the number of patients it would receive through selection and payment of a medical director?

The inconsistency of the enforcement agency's approach to the Statute also can be seen in the response of the Department of Health and Human Services ("HHS") to so-called "gainsharing" programs. Gainsharing is essentially a plan to align the economic incentives of hospitals and physicians to provide cost-effective care through a plan for sharing the resultant cost savings or revenue increases (the "gains") in some combination of a percentage payment, hourly fee, or fixed fee.

Early in the 1990s, HHS' Health Care Financing Administration ("HCFA") instituted a demonstration project for heart bypass services that has served as a genesis for a number of gainsharing programs.[3] The stated purpose of the demonstration project was to assess the feasibility and cost-effectiveness of a negotiated global (or bundled) payment arrangement for coronary artery bypass graft surgery while maintaining high-quality care. The seven participating hospitals received a global fee that covered Medicare Part A (which reimburses hospital services) and Part B (which reimburses physician services) and represented a substantial discount for Medicare from the otherwise applicable Part A and Part B rates. Hospitals and physicians were left to their own agreements as to how to allocate the global fees.

HCFA's report notes that apart from the demonstration project, all hospital-provided items and services were essentially free to the physicians because they bore none of the related financial risk. It was expected that the global fee would provide a means for hospital management to align incentives and encourage physicians to be more cost-

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[3] For an executive summary of HCFA's findings, see the Extramural Research Report on the Medicare Participating Heart Bypass Center Demonstration Project (Sept. 1998), available online at www.hcfa.gov/ord/ordhp1.htm. The entire report is in three volumes totaling approximately 900 pages and is available from the National Technical Information Service, (800) 553-NTIS.

effective consumers of hospital resources. One hospital in the demonstration project shared the gains with physicians through bonuses to individual surgeons based on documented cost savings to the hospital (up to 25% of the savings with no downside risk to their negotiated portion of the global fee). Surgeons were eligible for the gainsharing payments only if they met stringent quality and volume criteria. From HCFA's perspective, the demonstration project was a clear financial success, resulting in savings of approximately $50 million for the Medicare program and beneficiaries' copay obligations.

Despite these promising beginnings for gainsharing programs and a favorable review from the IRS (in two unpublished private letter rulings), the reaction of HHS' Office of Inspector General ("OIG") to privately developed gainsharing programs was much more negative. In response to pending requests for an advisory opinion that such programs did not violate the Anti-Kickback Statute or the related Civil Monetary Penalties ("CMP") law (42 U.S.C. § 1320a-7a(b)), OIG issued a Special Advisory Bulletin (July 1999, available at http://oig.hhs.gov/frdalrt/gainsh.htm). In the Bulletin, OIG concluded, again painting with a broad brush, that many gainsharing programs violated the CMP law and that "[g]ainsharing arrangements may also implicate the anti-kickback statute." Absent a clear safe harbor (and there is none), whether or not a gainsharing program violates the Anti-Kickback Statute depends on whether or not the requisite bad intent is present (following the same confusing, jurisdiction-by-jurisdiction standard outlined above). Perhaps the most troubling aspect of gainsharing programs under the Anti-Kickback Statute is that question of intent. Many gainsharing programs may be motivated at least in part by a desire of hospitals to increase specialty referrals or forestall competition from the growing number of niche, specialty hospitals in areas such as cardiac care and

oncology.[4] HHS' HCFA itself, however, acknowledged the benefits to the Medicare program of gainsharing in its Report on the Demonstration Project.

Not only do the differing "inducement" standards offered by the courts and agencies make it difficult to provide clear-cut advice to clients, the "one purpose" rule makes it impossible in some situations to provide legal assistance at all due to a concept akin to original sin. Assume that a client comes to a lawyer for advice about an innovative program that involves both "remuneration" (at fair market value for the benefit obtained) and "referrals." The client-representative tells the lawyer that the hospital has approved implementation of this program, because the hospital believes the program will fill a community need and provide more efficient care than other alternatives. During the conversation, he also mentions that the hospital president has expressed the belief that the program will enhance the hospital's revenues by providing patient referrals it would not receive absent implementation of the program.

The lawyer is in a quandary if he believes that client's overriding purpose in adopting the program is legitimate and will benefit the community, but the program is a new concept that cannot be shoehorned into a pre-existing safe harbor under the Statute. Because one decisionmaker had already expressed the view that patient referrals were a component of his evaluation of the program and decision to approve it, the transaction – if viewed through the lens of the "one purpose" doctrine – is forever tainted. No matter how much the company wants to comply with the law and wants the assistance of a lawyer to structure the transaction legally, it cannot unring the bell and proceed with certainty that its program will, in hindsight, be considered legal by a prosecutor or a court.

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[4] *See* M.C. Jaklevic, *Remembering the Specialists*, MODERN HEALTHCARE, April 26, 1999, at 35.

The health care lawyer's dilemma is further complicated by the conflict of the Anti-Kickback Statute with the Ethics in Patient Referrals Act (popularly known as the "Stark Law"), 42 U.S.C. § 1395nn – a conflict which is apparent but repeatedly and consciously ignored by OIG.[5] For example, OIG asserted in the recent safe harbor regulations that the Stark Law is a civil statute whereas the Anti-Kickback Statute is a criminal statute, the two statutes serve different purposes and the Stark Law does not have an intent element whereas the Anti-Kickback Statute does.[6] Although those distinctions may be technically accurate, the two statutory schemes do both regulate the business transactions of health care enterprises and they are administered by the same agency (HHS, through OIG for the Anti-Kickback Statute and HCFA for the Stark Law). The conflict of these statutory schemes, not to mention the conflict with the restrictions imposed by the Internal Revenue Service for tax-exempt health care providers, makes the compliance task a difficult one indeed for today's health care executives. Lack of a clear intent standard under the Anti-Kickback Statute, where intent is most relevant, is a significant contributing factor to that difficulty.

The practical realities of the health care industry were important to this Court's recent decision in *Pegram*. In that case, the Court interpreted ERISA's requirement that ERISA plan fiduciaries "discharge their duties . . . 'solely in the interest of the [plan] participants,'" 120 S. Ct. at 2151 (quoting 29 U.S.C. § 1002(21)(A)(iii)), in a context where the fiduciary was a Health Maintenance Organization. Citing congressional approval of managed care programs in the Health Maintenance Organization Act of 1973 and the

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[5] The Stark Law restricts referrals by a physician who has a financial relationship with the party to whom the referral was made, unless a specific statutory or regulatory exception applies.

[6] 64 Fed. Reg. 63517, 63519 – 63520 (Nov. 19, 1999).

practical economic concerns motivating the development of managed care plans, *id.* at 2156-57, the Court held that managed care plans could not be held liable for establishing incentive structures that might affect adversely the medical treatment of plan beneficiaries, even if the plans were ERISA fiduciaries for some purposes. *Id.* This Court therefore limited broad ERISA language in light of health care industry realities and congressional statements indicating that financial incentives affecting patient care decisions are not *per se* nefarious or wrongful. *Cf. United States v. Sun Diamond Growers*, 526 U.S. 398 (1999) (interpreting narrowly a criminal statute to prevent the criminalization of apparently innocent conduct). Likewise, this Court should intervene to provide clarity regarding the broadly-phrased intent standard of the Anti-Kickback Statute, in the face of industry realities and the express endorsement of health care delivery systems that necessarily marry the concepts of remuneration and referrals.

III. The Disarray In The Circuits and the "One Purpose" Standard in Particular Negatively Impact The Attorney-Client Relationship

If this Court now declines to bring the varying interpretations of the Anti-Kickback Statute into conformity, the relationship between health care clients and the attorneys that advise them about the fraud and abuse rules that govern their behavior will suffer. In the present legal environment, lawyers are placed in a position where they are unable to provide clear guidance concerning the legality of individual transactions and, indeed, must cautiously advise clients that nearly every transaction contains legal risk in light of the "one purpose" standard. This situation leads to frustration on the part of clients born of the perception that they are paying costly legal fees without receiving helpful input. Because the fraud and abuse rules are particularly complex, arcane and, in some instances, counterintuitive, it will disserve congressional intent to discourage health care

providers from seeking legal advice. Such discouragement may lead to more widespread adoption of transactions (without or against legal advice) that are not only in the gray area, but are clearly foreclosed under any of the legal standards in place.

Even if no client was deterred from seeking advice from lawyers in this environment, the message sent by the Tenth Circuit may cause clients to filter what they tell their lawyers. If clients become aware of the "original sin" problem discussed above and believe that a lawyer may refuse to assist in the drafting of a transaction, they will simply decline to apprise attorneys that a referral effect has, in fact, been considered. This filtering process is not necessarily indicative of an unlawful motive to violate the Anti-Kickback Statute, but will no doubt ensure that a lawyer's advice is not based upon the full and frank disclosure of all potentially relevant facts. Such an effect should not be encouraged.

The "one purpose" rule also increases the cost of legal services. An attorney asked to determine whether a particular transaction is legal in the Tenth Circuit must conduct an exhaustive investigation into the deliberative process of forming that transaction. Instead of acting through a client representative authorized to present the hospital's position, the attorney may feel obliged to interview every executive who commented upon the program in order to determine whether any one executive had, as "one purpose" of his decision to approve the program, the notion that the program would favorably impact referrals to the hospital. Moreover, many programs take years to develop or are implemented and renewed over several executive administrations. Must the attorney contact former executives to determine the initial intent of the program developers in order to ascertain whether the present executive board is placing the hospital at risk by renewing a particular program?

Increased legal costs may also arise out of the atmosphere of concern that has arisen in the wake of the indictment of two attorneys in this case. Fearing that they might be implicated in a conspiracy by assisting a client in drafting a contract without knowing the client had a motive to obtain patient referrals, attorneys may begin to document in memos to the file all oral communications with the client to preserve a record upon which the attorney's advice was based. Alternatively, attorneys may insist upon conducting all client interviews with more than one lawyer present, to prevent a "he said/she said" contest when an investigation begins. The fear motivating this self-protective behavior is more palpable in a world where the "one purpose" standard is the rule. If even incidental, immaterial motives alongside overwhelmingly legitimate motives are enough to make the transaction unlawful, attorneys will be less likely to be able discern from interactions with the client whether the client is motivated to obtain referrals.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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